

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-018830

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

FILED MAY 31 1962

Primary Registration District No. 1002

Registrar's No.

2400

STATE FILE NUMBER

|  |              |  |            |                       |
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| VS 300<br>Rev. 4/59                      | DATE AMENDED | AMENDMENTS ON THIS RECORD ARE AS FOLLOWS | INSTEAD OF | DOCUMENT              |
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| 13                                       |              |  |            |                       |
| USE BLACK INK<br>OR<br>TYPEWRITER RIBBON | SHOULD READ  | BY AFFIDAVIT OF                          | ITEM NO.   | MEDICAL CERTIFICATION |
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|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY JACKSON   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE MISSOURI b. COUNTY JACKSON  |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN KANSAS CITY   |   | Length of stay in 1b<br>5 hrs.  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION ST. LUKES HOSPITAL  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. CITY OR TOWN LEE'S SUMMIT   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| d. STREET ADDRESS Y-23 LAKE LOTAWANNA  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First ICIL Middle G. Last BETH   |   | 4. DATE OF DEATH<br>Month APRIL Day 29, Year 1962   |   |
| 5. SEX<br>FEMALE   | 6. COLOR OR RACE<br>WHITE   | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>                     | 8. DATE OF BIRTH<br>6-12-1903                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED SUPERVISOR  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>GRENAN BAKERY  |   |
| 11. BIRTHPLACE (City and state or country)<br>SULLIVAN COUNTY, MO.   |   | 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.   |   |
| 13a. FATHER'S NAME<br>CHARLEY DILLINER   |   | 13b. MOTHER'S MAIDEN NAME<br>MARY DODSON  |   |
| 14. NAME OF HUSBAND OR WIFE<br>CHARLEY D. BETH   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br>NO   |   |
| 16. SOCIAL SECURITY NO.<br>[REDACTED]  |   | 17. INFORMANT<br>Charley D. Beth, Lake Lotawanna Y-23   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Broncho pneumonia</i><br>DUE TO (b) <i>Bronchiectasis</i><br>DUE TO (c) _____<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. |   | INTERVAL BETWEEN ONSET AND DEATH<br>4 days.<br>7 years.   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |   |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |   |   |
| 21. I attended the deceased from 4-29-62 (12:30 P.M.) to 4-29-62 (5:55 P.M.) and last saw her alive on 4-29-62<br>Death occurred at 5:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.   |   | 22a. SIGNATURE<br>I. Byers M.D.<br>(Degree or title)  |   |
| 22b. ADDRESS<br>4320 W. Main Road, K.C. 11, Mo.  |   | 22c. DATE SIGNED<br>5-2-62  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL  | 23b. DATE<br>5-2-62   | 23c. NAME OF CEMETERY OR CREMATORY<br>GREENLAWN CEMETERY  | 23d. LOCATION (City, town, or county) (State)<br>KANSAS CITY, MO. |
| 24. FUNERAL DIRECTOR<br>GEO. C. CARSON & SONS, INDEPENDENCE, MOL   |   | 25. DATE RECD. BY LOCAL REG.<br>5-2-62  | 26. REGISTRAR'S SIGNATURE<br>Ruth Long                            |

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Charles F. Tyb*

Licensed Embalmer No.

*4534*

P. O. Address

*Forty Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.